

AMENDED IN SENATE MARCH 28, 2014

SENATE BILL

No. 1052

Introduced by Senator Torres

February 18, 2014

An act to amend Section 100503 of, *and to add Section 100503.1 to*, the Government Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1052, as amended, Torres. California Health Benefit Exchange: ~~annual report.~~ *report: qualified health plan formularies.*

Existing law establishes the California Health Benefit Exchange within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers. Existing law requires the board to undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange and to undertake outreach and enrollment activities that seek to assist with enrolling in the Exchange in the least burdensome manner. Existing law also requires the board of the Exchange to annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, as specified, and requires that this report be submitted to the Legislature and the Governor and be made available to the public on the Internet Web site of the Exchange.

This bill, ~~in addition,~~ would *also* require the report to include the total number of uninsured Californians as a percentage of the state population and an independent evaluation of the marketing and outreach and enrollment activities undertaken by the Exchange.

Existing law requires the board of the Exchange to determine the minimum requirements a carrier must meet to be considered for participation in the Exchange and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers.

This bill would prohibit the Exchange from offering a qualified health plan unless the carrier offering the plan posts the formulary for the plan on the Internet Web site of the carrier; updates that posting within 24 hours after making any changes to the formulary, uses a standard template to display the formulary for all qualified health plans offered by the carrier; and includes in any published formulary the prior authorization or step edit requirements for, and the range of coinsurance cost of, each drug included on the formulary. The bill would require the board of the Exchange to ensure that its Internet Web site provides a direct link to the formulary posted by a carrier before the plan is offered through the Exchange. The bill would also require the board to create a search tool on its Internet Web site that allows potential enrollees to search for qualified health plans by a particular drug and by a particular therapeutic condition.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 100503 of the Government Code, as
2 amended by Section 4 of Chapter 5 of the ~~1st~~ *First* Extraordinary
3 Session of the Statutes of 2013, is amended to read:
4 100503. In addition to meeting the minimum requirements of
5 Section 1311 of the federal act, the board shall do all of the
6 following:
7 (a) Determine the criteria and process for eligibility, enrollment,
8 and disenrollment of enrollees and potential enrollees in the
9 Exchange and coordinate that process with the state and local
10 government entities administering other health care coverage
11 programs, including the State Department of Health Care Services,
12 the Managed Risk Medical Insurance Board, and California
13 counties, in order to ensure consistent eligibility and enrollment
14 processes and seamless transitions between coverage.

1 (b) Develop processes to coordinate with the county entities
2 that administer eligibility for the Medi-Cal program and the entity
3 that determines eligibility for the Healthy Families Program,
4 including, but not limited to, processes for case transfer, referral,
5 and enrollment in the Exchange of individuals applying for
6 assistance to those entities, if allowed or required by federal law.

7 (c) Determine the minimum requirements a carrier must meet
8 to be considered for participation in the Exchange, and the
9 standards and criteria for selecting qualified health plans to be
10 offered through the Exchange that are in the best interests of
11 qualified individuals and qualified small employers. The board
12 shall consistently and uniformly apply these requirements,
13 standards, and criteria to all carriers. In the course of selectively
14 contracting for health care coverage offered to qualified individuals
15 and qualified small employers through the Exchange, the board
16 shall seek to contract with carriers so as to provide health care
17 coverage choices that offer the optimal combination of choice,
18 value, quality, and service.

19 (d) Provide, in each region of the state, a choice of qualified
20 health plans at each of the five levels of coverage contained in
21 subsections (d) and (e) of Section 1302 of the federal act.

22 (e) Require, as a condition of participation in the Exchange,
23 carriers to fairly and affirmatively offer, market, and sell in the
24 Exchange at least one product within each of the five levels of
25 coverage contained in subsections (d) and (e) of Section 1302 of
26 the federal act. The board may require carriers to offer additional
27 products within each of those five levels of coverage. This
28 subdivision shall not apply to a carrier that solely offers
29 supplemental coverage in the Exchange under paragraph (10) of
30 subdivision (a) of Section 100504.

31 (f) (1) Except as otherwise provided in this section and Section
32 100504.5, require, as a condition of participation in the Exchange,
33 carriers that sell any products outside the Exchange to do both of
34 the following:

35 (A) Fairly and affirmatively offer, market, and sell all products
36 made available to individuals in the Exchange to individuals
37 purchasing coverage outside the Exchange.

38 (B) Fairly and affirmatively offer, market, and sell all products
39 made available to small employers in the Exchange to small
40 employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code between the Managed Risk Medical Insurance Board and carriers for enrolled Healthy Families beneficiaries or contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and carriers for enrolled Medi-Cal beneficiaries. “Product” also does not include a bridge plan product offered pursuant to Section 100504.5.

(3) Except as required by Section 1301(a)(1)(C)(ii) of the federal act, a carrier offering a bridge plan product in the Exchange may limit the products it offers in the Exchange solely to a bridge plan product contract.

(g) Determine when an enrollee’s coverage commences and the extent and scope of coverage.

(h) Provide for the processing of applications and the enrollment and disenrollment of enrollees.

(i) Determine and approve cost-sharing provisions for qualified health plans.

(j) Establish uniform billing and payment policies for qualified health plans offered in the Exchange to ensure consistent enrollment and disenrollment activities for individuals enrolled in the Exchange.

(k) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.

(l) Select and set performance standards and compensation for navigators selected under subdivision (l) of Section 100502.

(m) Employ necessary staff.

(1) The board shall hire a chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a

1 general counsel, and other key executive positions, as determined
2 by the board, who shall be exempt from civil service.

3 (2) (A) The board shall set the salaries for the exempt positions
4 described in paragraph (1) and subdivision (i) of Section 100500
5 in amounts that are reasonably necessary to attract and retain
6 individuals of superior qualifications. The salaries shall be
7 published by the board in the board's annual budget. The board's
8 annual budget shall be posted on the Internet Web site of the
9 Exchange. To determine the compensation for these positions, the
10 board shall cause to be conducted, through the use of independent
11 outside advisors, salary surveys of both of the following:

12 (i) Other state and federal health insurance exchanges that are
13 most comparable to the Exchange.

14 (ii) Other relevant labor pools.

15 (B) The salaries established by the board under subparagraph
16 (A) shall not exceed the highest comparable salary for a position
17 of that type, as determined by the surveys conducted pursuant to
18 subparagraph (A).

19 (C) The Department of Human Resources shall review the
20 methodology used in the surveys conducted pursuant to
21 subparagraph (A).

22 (3) The positions described in paragraph (1) and subdivision (i)
23 of Section 100500 shall not be subject to otherwise applicable
24 provisions of the Government Code or the Public Contract Code
25 and, for those purposes, the Exchange shall not be considered a
26 state agency or public entity.

27 (n) Assess a charge on the qualified health plans offered by
28 carriers that is reasonable and necessary to support the
29 development, operations, and prudent cash management of the
30 Exchange. This charge shall not affect the requirement under
31 Section 1301 of the federal act that carriers charge the same
32 premium rate for each qualified health plan whether offered inside
33 or outside the Exchange.

34 (o) Authorize expenditures, as necessary, from the California
35 Health Trust Fund to pay program expenses to administer the
36 Exchange.

37 (p) Keep an accurate accounting of all activities, receipts, and
38 expenditures, and annually submit to the United States Secretary
39 of Health and Human Services a report concerning that accounting.

1 Commencing January 1, 2016, the board shall conduct an annual
2 audit.

3 (q) (1) (A) Annually prepare a written report on the
4 implementation and performance of the Exchange functions during
5 the preceding fiscal year, including, at a minimum, all of the
6 following:

7 (i) The manner in which funds were expended and the progress
8 toward, and the achievement of, the requirements of this title.

9 (ii) Data provided by health care service plans and health
10 insurers offering bridge plan products regarding the extent of health
11 care provider and health facility overlap in their Medi-Cal networks
12 as compared to the health care provider and health facility networks
13 contracting with the plan or insurer in their bridge plan contracts.

14 (iii) The total number of uninsured Californians as a percentage
15 of the state population.

16 (iv) An evaluation of the effectiveness of the activities
17 undertaken pursuant to subdivision (k). This evaluation shall be
18 conducted by an independent entity selected by the board.

19 (B) The report required by this paragraph shall be transmitted
20 to the Legislature and the Governor and shall be made available
21 to the public on the Internet Web site of the Exchange. A report
22 made to the Legislature pursuant to this paragraph shall be
23 submitted pursuant to Section 9795.

24 (2) The Exchange shall prepare, or contract for the preparation
25 of, an evaluation of the bridge plan program using the first three
26 years of experience with the program. The evaluation shall be
27 provided to the health policy and fiscal committees of the
28 Legislature in the fourth year following federal approval of the
29 bridge plan option. The evaluation shall include, but not be limited
30 to, all of the following:

31 (A) The number of individuals eligible to participate in the
32 bridge plan program each year by category of eligibility.

33 (B) The number of eligible individuals who elect a bridge plan
34 option each year by category of eligibility.

35 (C) The average length of time, by region and statewide, that
36 individuals remain in the bridge plan option each year by category
37 of eligibility.

38 (D) The regions of the state with a bridge plan option, and the
39 carriers in each region that offer a bridge plan, by year.

1 (E) The premium difference each year, by region, between the
2 bridge plan and the first and second lowest cost plan for individuals
3 in the Exchange who are not eligible for the bridge plan.

4 (F) The effect of the bridge plan on the premium subsidy amount
5 for bridge plan eligible individuals each year by each region.

6 (G) Based on a survey of individuals enrolled in the bridge plan:

7 (i) Whether individuals enrolling in the bridge plan product are
8 able to keep their existing health care providers.

9 (ii) Whether individuals would want to retain their bridge plan
10 product, buy a different Exchange product, or decline to purchase
11 health insurance if there was no bridge plan product available. The
12 Exchange may include questions designed to elicit the information
13 in this subparagraph as part of an existing survey of individuals
14 receiving coverage in the Exchange.

15 (3) In addition to the evaluation required by paragraph (2), the
16 Exchange shall post the items in subparagraphs (A) to (F),
17 inclusive, on its Internet Web site each year.

18 (4) In addition to the report described in paragraph (1), the board
19 shall be responsive to requests for additional information from the
20 Legislature, including providing testimony and commenting on
21 proposed state legislation or policy issues. The Legislature finds
22 and declares that activities including, but not limited to, responding
23 to legislative or executive inquiries, tracking and commenting on
24 legislation and regulatory activities, and preparing reports on the
25 implementation of this title and the performance of the Exchange,
26 are necessary state requirements and are distinct from the
27 promotion of legislative or regulatory modifications referred to in
28 subdivision (d) of Section 100520.

29 (r) Maintain enrollment and expenditures to ensure that
30 expenditures do not exceed the amount of revenue in the fund, and
31 if sufficient revenue is not available to pay estimated expenditures,
32 institute appropriate measures to ensure fiscal solvency.

33 (s) Exercise all powers reasonably necessary to carry out and
34 comply with the duties, responsibilities, and requirements of this
35 act and the federal act.

36 (t) Consult with stakeholders relevant to carrying out the
37 activities under this title, including, but not limited to, all of the
38 following:

39 (1) Health care consumers who are enrolled in health plans.

1 (2) Individuals and entities with experience in facilitating
2 enrollment in health plans.

3 (3) Representatives of small businesses and self-employed
4 individuals.

5 (4) The State Medi-Cal Director.

6 (5) Advocates for enrolling hard-to-reach populations.

7 (u) Facilitate the purchase of qualified health plans in the
8 Exchange by qualified individuals and qualified small employers
9 no later than January 1, 2014.

10 (v) Report, or contract with an independent entity to report, to
11 the Legislature by December 1, 2018, on whether to adopt the
12 option in Section 1312(c)(3) of the federal act to merge the
13 individual and small employer markets. In its report, the board
14 shall provide information, based on at least two years of data from
15 the Exchange, on the potential impact on rates paid by individuals
16 and by small employers in a merged individual and small employer
17 market, as compared to the rates paid by individuals and small
18 employers if a separate individual and small employer market is
19 maintained. A report made pursuant to this subdivision shall be
20 submitted pursuant to Section 9795.

21 (w) With respect to the SHOP Program, collect premiums and
22 administer all other necessary and related tasks, including, but not
23 limited to, enrollment and plan payment, in order to make the
24 offering of employee plan choice as simple as possible for qualified
25 small employers.

26 (x) Require carriers participating in the Exchange to immediately
27 notify the Exchange, under the terms and conditions established
28 by the board when an individual is or will be enrolled in or
29 disenrolled from any qualified health plan offered by the carrier.

30 (y) Ensure that the Exchange provides oral interpretation
31 services in any language for individuals seeking coverage through
32 the Exchange and makes available a toll-free telephone number
33 for the hearing and speech impaired. The board shall ensure that
34 written information made available by the Exchange is presented
35 in a plainly worded, easily understandable format and made
36 available in prevalent languages.

37 (z) This section shall become inoperative on the October 1 that
38 is five years after the date that federal approval of the bridge plan
39 option occurs, and, as of the second January 1 thereafter, is
40 repealed, unless a later enacted statute that is enacted before that

1 date deletes or extends the dates on which it becomes inoperative
2 and is repealed.

3 SEC. 2. Section 100503 of the Government Code, as added by
4 Section 5 of Chapter 5 of the ~~1st~~ *First* Extraordinary Session of
5 the Statutes of 2013, is amended to read:

6 100503. In addition to meeting the minimum requirements of
7 Section 1311 of the federal act, the board shall do all of the
8 following:

9 (a) Determine the criteria and process for eligibility, enrollment,
10 and disenrollment of enrollees and potential enrollees in the
11 Exchange and coordinate that process with the state and local
12 government entities administering other health care coverage
13 programs, including the State Department of Health Care Services,
14 the Managed Risk Medical Insurance Board, and California
15 counties, in order to ensure consistent eligibility and enrollment
16 processes and seamless transitions between coverage.

17 (b) Develop processes to coordinate with the county entities
18 that administer eligibility for the Medi-Cal program and the entity
19 that determines eligibility for the Healthy Families Program,
20 including, but not limited to, processes for case transfer, referral,
21 and enrollment in the Exchange of individuals applying for
22 assistance to those entities, if allowed or required by federal law.

23 (c) Determine the minimum requirements a carrier must meet
24 to be considered for participation in the Exchange, and the
25 standards and criteria for selecting qualified health plans to be
26 offered through the Exchange that are in the best interests of
27 qualified individuals and qualified small employers. The board
28 shall consistently and uniformly apply these requirements,
29 standards, and criteria to all carriers. In the course of selectively
30 contracting for health care coverage offered to qualified individuals
31 and qualified small employers through the Exchange, the board
32 shall seek to contract with carriers so as to provide health care
33 coverage choices that offer the optimal combination of choice,
34 value, quality, and service.

35 (d) Provide, in each region of the state, a choice of qualified
36 health plans at each of the five levels of coverage contained in
37 subsections (d) and (e) of Section 1302 of the federal act.

38 (e) Require, as a condition of participation in the Exchange,
39 carriers to fairly and affirmatively offer, market, and sell in the
40 Exchange at least one product within each of the five levels of

1 coverage contained in subsections (d) and (e) of Section 1302 of
2 the federal act. The board may require carriers to offer additional
3 products within each of those five levels of coverage. This
4 subdivision shall not apply to a carrier that solely offers
5 supplemental coverage in the Exchange under paragraph (10) of
6 subdivision (a) of Section 100504.

7 (f) (1) Require, as a condition of participation in the Exchange,
8 carriers that sell any products outside the Exchange to do both of
9 the following:

10 (A) Fairly and affirmatively offer, market, and sell all products
11 made available to individuals in the Exchange to individuals
12 purchasing coverage outside the Exchange.

13 (B) Fairly and affirmatively offer, market, and sell all products
14 made available to small employers in the Exchange to small
15 employers purchasing coverage outside the Exchange.

16 (2) For purposes of this subdivision, “product” does not include
17 contracts entered into pursuant to Part 6.2 (commencing with
18 Section 12693) of Division 2 of the Insurance Code between the
19 Managed Risk Medical Insurance Board and carriers for enrolled
20 Healthy Families beneficiaries or contracts entered into pursuant
21 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
22 (commencing with Section 14200) of, Part 3 of Division 9 of the
23 Welfare and Institutions Code between the State Department of
24 Health Care Services and carriers for enrolled Medi-Cal
25 beneficiaries.

26 (g) Determine when an enrollee’s coverage commences and the
27 extent and scope of coverage.

28 (h) Provide for the processing of applications and the enrollment
29 and disenrollment of enrollees.

30 (i) Determine and approve cost-sharing provisions for qualified
31 health plans.

32 (j) Establish uniform billing and payment policies for qualified
33 health plans offered in the Exchange to ensure consistent
34 enrollment and disenrollment activities for individuals enrolled in
35 the Exchange.

36 (k) Undertake activities necessary to market and publicize the
37 availability of health care coverage and federal subsidies through
38 the Exchange. The board shall also undertake outreach and
39 enrollment activities that seek to assist enrollees and potential
40 enrollees with enrolling and reenrolling in the Exchange in the

1 least burdensome manner, including populations that may
2 experience barriers to enrollment, such as the disabled and those
3 with limited English language proficiency.

4 (l) Select and set performance standards and compensation for
5 navigators selected under subdivision (l) of Section 100502.

6 (m) Employ necessary staff.

7 (1) The board shall hire a chief fiscal officer, a chief operations
8 officer, a director for the SHOP Exchange, a director of Health
9 Plan Contracting, a chief technology and information officer, a
10 general counsel, and other key executive positions, as determined
11 by the board, who shall be exempt from civil service.

12 (2) (A) The board shall set the salaries for the exempt positions
13 described in paragraph (1) and subdivision (i) of Section 100500
14 in amounts that are reasonably necessary to attract and retain
15 individuals of superior qualifications. The salaries shall be
16 published by the board in the board's annual budget. The board's
17 annual budget shall be posted on the Internet Web site of the
18 Exchange. To determine the compensation for these positions, the
19 board shall cause to be conducted, through the use of independent
20 outside advisors, salary surveys of both of the following:

21 (i) Other state and federal health insurance exchanges that are
22 most comparable to the Exchange.

23 (ii) Other relevant labor pools.

24 (B) The salaries established by the board under subparagraph
25 (A) shall not exceed the highest comparable salary for a position
26 of that type, as determined by the surveys conducted pursuant to
27 subparagraph (A).

28 (C) The Department of Human Resources shall review the
29 methodology used in the surveys conducted pursuant to
30 subparagraph (A).

31 (3) The positions described in paragraph (1) and subdivision (i)
32 of Section 100500 shall not be subject to otherwise applicable
33 provisions of the Government Code or the Public Contract Code
34 and, for those purposes, the Exchange shall not be considered a
35 state agency or public entity.

36 (n) Assess a charge on the qualified health plans offered by
37 carriers that is reasonable and necessary to support the
38 development, operations, and prudent cash management of the
39 Exchange. This charge shall not affect the requirement under
40 Section 1301 of the federal act that carriers charge the same

1 premium rate for each qualified health plan whether offered inside
2 or outside the Exchange.

3 (o) Authorize expenditures, as necessary, from the California
4 Health Trust Fund to pay program expenses to administer the
5 Exchange.

6 (p) Keep an accurate accounting of all activities, receipts, and
7 expenditures, and annually submit to the United States Secretary
8 of Health and Human Services a report concerning that accounting.
9 Commencing January 1, 2016, the board shall conduct an annual
10 audit.

11 (q) (1) (A) Annually prepare a written report on the
12 implementation and performance of the Exchange functions during
13 the preceding fiscal year, including, at a minimum, all of the
14 following:

15 (i) The manner in which funds were expended and the progress
16 toward, and the achievement of, the requirements of this title.

17 (ii) The total number of uninsured Californians as a percentage
18 of the state population.

19 (iii) An evaluation of the effectiveness of the activities
20 undertaken pursuant to subdivision (k). This evaluation shall be
21 conducted by an independent entity selected by the board.

22 (B) The report required by this paragraph shall be transmitted
23 to the Legislature and the Governor and shall be made available
24 to the public on the Internet Web site of the Exchange. A report
25 made to the Legislature pursuant to this paragraph shall be
26 submitted pursuant to Section 9795.

27 (2) In addition to the report described in paragraph (1), the board
28 shall be responsive to requests for additional information from the
29 Legislature, including providing testimony and commenting on
30 proposed state legislation or policy issues. The Legislature finds
31 and declares that activities including, but not limited to, responding
32 to legislative or executive inquiries, tracking and commenting on
33 legislation and regulatory activities, and preparing reports on the
34 implementation of this title and the performance of the Exchange,
35 are necessary state requirements and are distinct from the
36 promotion of legislative or regulatory modifications referred to in
37 subdivision (d) of Section 100520.

38 (r) Maintain enrollment and expenditures to ensure that
39 expenditures do not exceed the amount of revenue in the fund, and

1 if sufficient revenue is not available to pay estimated expenditures,
2 institute appropriate measures to ensure fiscal solvency.

3 (s) Exercise all powers reasonably necessary to carry out and
4 comply with the duties, responsibilities, and requirements of this
5 act and the federal act.

6 (t) Consult with stakeholders relevant to carrying out the
7 activities under this title, including, but not limited to, all of the
8 following:

9 (1) Health care consumers who are enrolled in health plans.

10 (2) Individuals and entities with experience in facilitating
11 enrollment in health plans.

12 (3) Representatives of small businesses and self-employed
13 individuals.

14 (4) The State Medi-Cal Director.

15 (5) Advocates for enrolling hard-to-reach populations.

16 (u) Facilitate the purchase of qualified health plans in the
17 Exchange by qualified individuals and qualified small employers
18 no later than January 1, 2014.

19 (v) Report, or contract with an independent entity to report, to
20 the Legislature by December 1, 2018, on whether to adopt the
21 option in Section 1312(c)(3) of the federal act to merge the
22 individual and small employer markets. In its report, the board
23 shall provide information, based on at least two years of data from
24 the Exchange, on the potential impact on rates paid by individuals
25 and by small employers in a merged individual and small employer
26 market, as compared to the rates paid by individuals and small
27 employers if a separate individual and small employer market is
28 maintained. A report made pursuant to this subdivision shall be
29 submitted pursuant to Section 9795.

30 (w) With respect to the SHOP Program, collect premiums and
31 administer all other necessary and related tasks, including, but not
32 limited to, enrollment and plan payment, in order to make the
33 offering of employee plan choice as simple as possible for qualified
34 small employers.

35 (x) Require carriers participating in the Exchange to immediately
36 notify the Exchange, under the terms and conditions established
37 by the board when an individual is or will be enrolled in or
38 disenrolled from any qualified health plan offered by the carrier.

39 (y) Ensure that the Exchange provides oral interpretation
40 services in any language for individuals seeking coverage through

1 the Exchange and makes available a toll-free telephone number
2 for the hearing and speech impaired. The board shall ensure that
3 written information made available by the Exchange is presented
4 in a plainly worded, easily understandable format and made
5 available in prevalent languages.

6 (z) This section shall become operative only if Section 4 of the
7 act that added this section becomes inoperative pursuant to
8 subdivision (z) of that Section 4.

9 *SEC. 3. Section 100503.1 is added to the Government Code,*
10 *to read:*

11 *100503.1. (a) A qualified health plan shall not be offered*
12 *through the Exchange unless the carrier offering the plan does all*
13 *of the following:*

14 *(1) Posts the formulary for the qualified health plan on the*
15 *Internet Web site of the carrier in a manner that is accessible and*
16 *searchable by potential enrollees, enrollees, and providers.*

17 *(2) Updates the formulary posted pursuant to paragraph (1)*
18 *with any change to that formulary within 24 hours after making*
19 *the change.*

20 *(3) Uses a standard template to display the formulary for all*
21 *qualified health plans offered by the carrier. This template shall*
22 *do both of the following:*

23 *(A) Use the United States Pharmacopeia classification system.*

24 *(B) Organize drugs by therapeutic class, listing drugs*
25 *alphabetically.*

26 *(4) Includes both of the following on any published formulary*
27 *for the qualified health plan, including, but not limited to, the*
28 *formulary posted pursuant to paragraph (1):*

29 *(A) Any prior authorization or step edit requirements for each*
30 *specific drug included on the formulary.*

31 *(B) The range of coinsurance cost to a potential enrollee of*
32 *each specific drug included on the formulary, as follows:*

33 *(i) Under \$100 – \$.*

34 *(ii) \$100-\$250 – \$\$.*

35 *(iii) \$251-\$500 – \$\$\$.*

36 *(iv) Over \$500 – \$\$\$\$.*

37 *(b) The board shall ensure that the Internet Web site maintained*
38 *under subdivision (c) of Section 100502 provides a direct link to*
39 *the formulary posted pursuant to paragraph (1) of subdivision (a)*
40 *before the plan is offered through the Exchange.*

1 (c) *The board shall create a search tool on the Internet Web*
2 *site maintained under subdivision (c) of Section 100502 that allows*
3 *potential enrollees to search for qualified health plans by a*
4 *particular drug and by a particular therapeutic condition.*

5 (d) *For purposes of this section, “formulary for the qualified*
6 *health plan” means the complete list of drugs preferred for use*
7 *and eligible for coverage under the qualified health plan and*
8 *includes the drugs covered under both the pharmacy benefit of the*
9 *plan and the medical benefit of the plan.*